

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G218	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/14/2008
NAME OF PROVIDER OR SUPPLIER WHOLISTIC SERVICES, X			STREET ADDRESS, CITY, STATE, ZIP CODE 1418 VAN BUREN STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 000	INITIAL COMMENTS On October 27, 2008 at 3:38 PM, the State Agency (SA) received an unusual incident report (UIR) via facsimile regarding Client #1. According to the UIR, on October 23, 2008 at 5:50 PM, the direct staff noticed that Client #1's right leg was swollen from her knee to her ankle. The direct care staff reported the findings to the house manager (HM). The HM informed the Registered Nurse (RN) on the same day. The RN instructed the House manager, who was a Trained Medication Employee (TME) to administer PRN (as needed) medication for pain. The Primary Care Physician (PCP) evaluated the client on the following day, October 24, 2008. The PCP ordered an x-ray of the client's right leg, which revealed that the client sustained a right distal fibular fracture. Due to the nature of the incident an on site investigation was initiated on October 29, 2008 to evaluate the facility's system's for ensuring health and safety to its clients. The findings of the investigation was based on observation at the group home and the day program; interviews with group home staff, day program staff, the Qualified Mental Retardation Professional(QMRP), the Registered Nurse and the HM; and the review of medical/clinical/administrative records.	W 000	<p><i>Received 12/4/08</i></p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p>		
W 114	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Based on interview and record review, the facility	W 114			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Matthew Thomas

Paul Drecht Vice President

12/2/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08G218	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/14/2008
NAME OF PROVIDER OR SUPPLIER WHOLISTIC SERVICES, X			STREET ADDRESS, CITY, STATE, ZIP CODE 1419 VAN BUREN STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 114	Continued From page 1 failed to ensure the Primary Care Physician (PCP) dated all entries made in Client #1's medical record. The finding includes: On October 23, 2008 the direct staff noticed that Client #1's right leg was swollen from her knee to her ankle. The direct care staff reported the findings to the house manager. The house manager informed the Registered Nurse (RN) on the same day. The RN instructed the House manager, who was a Trained Medication Employee (TME) to administer pain medication to the client. The Primary Care Physician (PCP) evaluated the client on October 24, 2008. Interview with the Registered Nurse on October 28, 2008, at 11:30 AM revealed that the physician evaluated the client on October 24, 2008. Review of the client's record on the same day revealed a consultation form which which documented the client's diagnosis and treatment plan. Although the physician signed the form, the physician failed to date the form.	W 114	<div style="border: 1px solid black; padding: 5px;"> <p>W 114 The physician has received a copy of this statement of deficiencies. The administration has had verbal discussions with the physician on this subject. It is going to be a mandate on all Direct Care Staff (DCS), Qualified Mental Retardation Professionals (QMRPs), the administration, and nurses to ensure that the physician date and signs all documents reviewed before leaving the physician's office. 12/01/08</p> </div>		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all unusual incidents including injuries of unknown origin were reported	W 153			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G218	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/14/2008
-----------------------------------------------------	---------------------------------------------------------------------	------------------------------------------------------------------	------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER

WHOLISTIC SERVICES, X

STREET ADDRESS, CITY, STATE, ZIP CODE

1419 VAN BUREN STREET, NW

WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------------	------------------------------------------------------------------------------------------------------------------------------	---------------------	--------------------------------------------------------------------------------------------------------------------------	----------------------------

W 153

Continued From page 2

Immediately to the administrator and other officials according to District of Columbia Regulations (22 DCMR, Chapter 35, Section 3519.10) one of one client in the investigation. (Client #1)

The finding includes:

Review of an unusual incident report dated October 23, 2008, on October 29, 2008 revealed that Client #1 was discovered to have sustained swelling to the right leg from the knee to the ankle. The origin of the swelling was unknown. The incident report reflected that the client's leg was x-rayed on October 24, 2008 and revealed the client had a right distal fibular fracture. Further review of the Verbal Notification/Written Notification section of the incident report failed to show evidence that this incident had been reported immediately to the administrator or governmental agencies as required. Additionally the incident report reflects an October 27, 2008 date of notification to the State Agency (four days after the swelling was discovered).

W 153

W 153

Staff have been trained on policies and procedures of incident reporting. The emphasis of the training was timely (within 24 hours) verbal/written notification of all agencies regarding an incident. In the future, the QMRP will work collaboratively with the incident management coordinator on this subject to ensure compliance.

12/01/08

W 156

483.420(d)(4) STAFF TREATMENT OF CLIENTS

The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.

This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to report the results of all investigations to the administrator or designated representative or to other officials in accordance with State Law within five working days of the incident.

W 156

The investigation report was submitted to Wholistic Services' administration on 10/30/08 which is within five working days of the date of the incident report.

12/01/08

IN THE FUTURE, PROVIDER WILL ENSURE SUBMITTED 5 DAYS FROM INCIDENT. 12/1/08

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G218	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/14/2008
-----------------------------------------------------	---------------------------------------------------------------------	------------------------------------------------------------------	------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER

WHOLISTIC SERVICES, X

STREET ADDRESS, CITY, STATE, ZIP CODE

1419 VAN BUREN STREET, NW
WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 156	Continued From page 3 The finding includes: On October 29, 2008, the Qualified Mental retardation Professional (QMRP) was asked if the incident was being investigated by the provider. The QMRP indicated that it was being investigated; however as of October 29, 2008, the investigation had not been completed.	W 156		
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure employees were effectively trained to provide for each client's healthcare needs, for Client #1. The finding includes: Cross reference to W331.6. Client #1 was observed at the facility on October 29, 2008 and October 30, 2008 not having her legs elevated as written in the nursing protocol. Additionally, the day program staff revealed that the clients legs were not elevated while there on October 29, 2008. Review of the training documentation revealed that the nurses provided training to staff six day after the swelling was noticed.	W 192	W 192 In the future, the facility's Registered Nurse (RN) shall ensure that staff training is done within 24 hours of the stipulated implementation of a protocol. The House Manager, QMRP, and the RN shall on a daily basis monitor staff to ensure compliance. In the case of an acute medical condition, the facility shall hold a case conference with the day program's Interdisciplinary Team (IDT) to discuss the client's plan of treatment prior to returning to his/her day program. 12/01/08	
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care.	W 322		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08G218	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/14/2008
NAME OF PROVIDER OR SUPPLIER WHOLISTIC SERVICES, X			STREET ADDRESS, CITY, STATE, ZIP CODE 1419 VAN BUREN STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 322	Continued From page 4 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure general and preventative care services, for one of the one client in the investigation. (Client #1) The findings include: The facility failed to ensure basic care for swelling of the leg at the group home and day program. Interview with the Registered Nurse (RN) on October 29, 2008 at approximately 10:30 AM revealed that Client #1's right leg was swollen and x-rays revealed that she had sustained a right distal fibular fracture. The nurse instructed the direct care staff to implement the "RICE Principle" (Rest, Ice, Compression and Elevation). The nurse instructed the staff to elevate Client #1's leg while sitting and in bed. Observations on the same day at approximately 3:30 PM failed to evidence that the staff elevated the client's leg when sitting. Additionally, the client returned to the day program on October 19, 2008. Interview with the day program staff revealed that they were not aware of the clients fracture until 1:45 PM, four hours after the client arrived. According to the day program staff, the client was allowed to walk around the gymnasium and track and was not encouraged to elevate her leg while there. There was no evidence that the facility gave timely instructions to the day program to restrict the clients activities and or to provide preventative care by elevating her leg while sitting.	W 322	W 322 Cross Reference W192. 12/01/08		
W 331	482.480(c) NURSING SERVICES	W 331			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G218	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/14/2008
NAME OF PROVIDER OR SUPPLIER WHOLISTIC SERVICES, X			STREET ADDRESS, CITY, STATE, ZIP CODE 1419 VAN BUREN STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 331	<p>Continued From page 5</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>This STANDARD is not met as evidenced by: Based on interviews, and record verification, the facility's nursing services failed to establish systems to provide health care monitoring and identify services in accordance with clients' needs for one of one client in the investigation. (Client #1)</p> <p>The findings include:</p> <p>1. The facility's Registered Nurse (RN) failed to immediately report Client #1's swollen leg of unknown origin to the Primary Care Physician (PCP) timely.</p> <p>Interview with RN on October 29, 2008 and review of the incident report revealed that on October 23, 2008, at 8:50 PM, the house Manager was informed by the direct care staff that Client #1's right leg was swollen. The swelling was described as "from the knee down to the ankle." The House manager, reported the finding to the RN at 7:00 PM. The RN instructed the HM, who happened to be a trained medication employee (TME), to administer PRN (as needed) pain medication. On October 29, 2008 at approximately 11:00 AM, the nurse was asked why the physician was not notified on October 23, 2008? Originally the RN indicated that the physician's office was closed at the time she was notified, however, when asked if the physician was available 24 hours, she indicated that the physician was available 24 hours. The nurse stated that she decided that she would send the client to his office the next day. It was noted that</p>	W 331	<p>W 331.1 The administration and the QMRP held discussions with the RN on the deficiency statements. Emphases of the meeting were timely notification (within 24 hours) of the primary care physician of an incident, and timely treatment intervention.</p> <p>The administration will hold monthly meetings with nurses, and QMRPs to discuss best practices. 12/01/08</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G218	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/14/2008
NAME OF PROVIDER OR SUPPLIER WHOLISTIC SERVICES, X			STREET ADDRESS, CITY, STATE, ZIP CODE 1419 VAN BUREN STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 331	<p>Continued From page 6</p> <p>x-rays obtained on October 24, 2008 revealed the client sustained a right distal fibular fracture.</p> <p>In addition, the RN did not evaluate the clients leg until 8:00 AM on October 24, 2008. Review of the the facility's policy on Communication of Medically Related Issues, November 6, 2008 at approximately 1:40 PM revealed that new medical issues should be communicated to the physician. Although the policy indicated that the nurse would "prioritize " verbal notification to the physician, the person who originally notified the RN was not a nurse and therefor could not fully attest to the extent of the swelling, i.e. were pulses present, or if pitting edema was present.</p> <p>Interview with the PCP on November 14, 2008 at approximately 4:45 PM, revealed that he would have preferred to know about the client's swollen leg when it was discovered.</p> <p>2. The facility's RN failed to obtain clearance from the PCP to send Client #1 to her day program.</p> <p>Observation at the group home on October 29 , 2008 at 9:30 AM revealed that the client was not present. Interview with RN on the same day at approximately 11:50 AM revealed that the client was at her day program. When asked if the physician had cleared the client to go to her day program she indicated that he had not given an order and that she authorized the staff to take the client to her day program. Review of the medical record on the same day revealed that on October 24, 2008, Client #1 was transported to her physician's office for evaluation of the swelling to her right leg. The physician requested that an x-ray be performed on the client's leg. The x-ray was performed on the same day and revealed</p>	W 331	<p>W 331.2</p> <p>It is the practice of Wholistic Services that in a situation where a client is absent from his/her day program due to medical reasons, a clearance be obtained from the client's primary care physician prior to his/her return to the day program.</p> <p>The facility has reviewed such protocol with the RN and House Manager. The QMRP will work with the RN and House Manager to ensure compliance.</p> <p style="text-align: right;">12/01/08</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G218	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/14/2008
-----------------------------------------------------	---------------------------------------------------------------------	------------------------------------------------------------------	------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER

WHOLISTIC SERVICES, X

STREET ADDRESS, CITY, STATE, ZIP CODE
1419 VAN BUREN STREET, NW
WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 331	<p>Continued From page 7</p> <p>that Client #1 had a right distal fibular fracture. The physician recommended that the client be evaluated by an Orthopedic Surgeon (OS). The RN indicated that the client was scheduled to see the Orthopedic Surgeon on November 11, 2008. When asked if the physician was aware that the client was being sent to the day program prior to being seen by the OS, the nurse stated that the PCP was not aware and had not given orders to send the client to the day program, or to restrict her activities.</p> <p>Interview with the PCP on November 14, 2008 at approximately 4:45 PM, revealed that he preferred that the client see the specialist and then be re-evaluated by him prior to the client returning to the day program.</p> <p>3. The facility's nursing staff failed to ensure that the day program staff was aware of Client #1's fracture.</p> <p>The day program staff was interviewed on October 29, 2008 at approximately 2:45 PM. When asked what types of activities the client participated in while at the program, he indicated that she walks around the gymnasium about four times per day and around the track about two times per day. When asked if he was aware that the client had a fracture to her right leg he indicated that he was not aware until approximately 1:30 PM to 1:45 PM. He further indicated that had he known about her injury he would not have allowed her to be at the day program until cleared by the physician. When asked if there was any correspondence or call from the group home regarding the client's condition, he indicated that there was no call from</p>	W 331	<p>W 331.3 Cross Reference W192.</p> <p>12/01/08</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

09G218

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
COMPLETED

C

11/14/2008

NAME OF PROVIDER OR SUPPLIER

WHOLISTIC SERVICES, X

STREET ADDRESS, CITY, STATE, ZIP CODE
1419 VAN BUREN STREET, NW
WASHINGTON, DC 20012

(X4) ID
PREFIX
TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID
PREFIX
TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X5)
COMPLETION
DATE

W 331

Continued From page 8
the facility.

The driver who transported the client to the day program at 10:15 AM delivered two envelopes that were addressed to the nurse. The correspondence was addressed to the nurse. The day program staff stated the nurse was not present at the time the client arrived to the day program. The TME however, arrived at the day program at approximately 1:30 -1:45 PM. The TME indicated he had to seek further clarification regarding the client's fracture, however, when asked if the TME administered medication to Client #1, the day program staff indicated "no."

Interview with the facility's Registered Nurse on the same day at approximately 3:00 PM revealed that she was not aware that the day program did not have nursing staff available on the premises.

4. The facility's nursing staff failed to update the clients care plan to reflect the change in the clients condition.

Review of the Health Management Care Plan on October 29, 2008 failed to reflect the management of Client #1's swollen leg. Interview with the nurse acknowledged that the document located in the clients record had not been updated.

5. The facility's nurse failed to obtain care/treatment orders for Client #1.

Interview with the facility's nurse on October 29, 2008 at 11:30 AM, revealed that she had put in place the "RICE Principle" (Rest, Ice, Compression and Elevation) for staff to follow. The compression component of the protocol

W 331

W 331.4

The client's care plan has been updated. In the future, such plan shall be updated within 24 hours of the occurrence of an incident.

The QMRP shall review the updated plan with the RN to ensure that change in the client's health is addressed.

12/01/08

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

090218

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

(X3) DATE SURVEY
COMPLETED

C

11/14/2008

NAME OF PROVIDER OR SUPPLIER

WHOLISTIC SERVICES, X

STREET ADDRESS, CITY, STATE, ZIP CODE
1418 VAN BUREN STREET, NW
WASHINGTON, DC 20012

(X4) ID
PREFIX
TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID
PREFIX
TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X5)
COMPLETION
DATE

W 331

Continued From page 9

requires that an ace wrap be place on the clients right leg. When asked if the Physician ordered the ace wrap, the RN indicated that the Physician verbally instructed her to use the ace wrap, however review of the Physician's Orders on the same day failed to reflect an order.

6. The facility's nursing staff to ensure timely training to the direct care staff regarding Client #1's fractured fibular.

On October 29, 2008 at approximately 3:30 PM and 4:45 PM Client #1 was observed sitting in a chair in with her feet on the floor. In an interview with the RN earlier the same day, she stated that the clients legs were to be elevated while sitting. Training documentation presented to the surveyor on October 30, 2008, revealed that the staff received training on the "RICE Principle" and the "fracture to right leg" on October 29, 2008, six after the swelling was noticed.

7. Cross refer to W366. The facility's nursing services failed to ensure that all drugs were administered in compliance with the physician's orders.

W 340

483.460(c)(5)(i) NURSING SERVICES

Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.

This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's nursing services failed to

W 331

W 331.5

The RN has been advised to ensure that verbal instructions are reflected on the Physician's Order Sheets (POSS), and to consistently adhere to Physician's Orders (POSS).

The RN will on a monthly basis review the POSS to ensure compliance.

12/01/08

W 331.6

Cross Reference W 192.

12/01/08

W 340

W 331.7

Cross reference W331.5.

12/01/08

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

09G218

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
COMPLETED

C

11/14/2008

NAME OF PROVIDER OR SUPPLIER

WHOLISTIC SERVICES, X

STREET ADDRESS, CITY, STATE, ZIP CODE
1419 VAN BUREN STREET, NW
WASHINGTON, DC 20012

(X4) ID
PREFIX
TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID
PREFIX
TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X5)
COMPLETION
DATE

W 340

Continued From page 10
Implement an effective system to ensure training
to clients and staff in preventive health measures
for one of one client in the investigation. (Client
#1)

The finding includes:

Cross reference to W331.6. Client #1 was
observed at the facility on October 28, 2008 and
October 30, 2008 not having her legs elevated as
written in the nursing protocol. Additionally, the
day program staff revealed that the clients legs
were not elevated while there on October 29,
2008. Review of the training documentation
revealed that the nurses provided training to staff
six day after the swelling was noticed.

W 340

W 340

Cross Reference W331.6.

12/01/08

Health Regulation Administration

PRINTED: 11/21/2008
FORM APPROVEDSTATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

09G218

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
COMPLETED

C

11/14/2008

NAME OF PROVIDER OR SUPPLIER

WHOLISTIC SERVICES, X

STREET ADDRESS, CITY, STATE, ZIP CODE

1415 VAN BUREN STREET, NW
WASHINGTON, DC 20012(X4) ID
PREFIX
TAGSUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)ID
PREFIX
TAGPROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)(X5)
COMPLETE
DATE

1 000 INITIAL COMMENTS

On October 27, 2008 at 3:36 PM, the State Agency (SA) received an unusual incident report (UIR) via facsimile regarding Resident #1. According to the UIR, on October 23, 2008 at 6:50 PM, the direct staff noticed that Resident #1's right leg was swollen from her knee to her ankle. The direct care staff reported the findings to the house manager (HM). The HM informed the Registered Nurse (RN) on the same day. The RN instructed the House manager, who was a Trained Medication Employee (TME) to administer PRN (as needed) medication for pain. The Primary Care Physician (PCP) evaluated the client on October 24, 2008. The PCP ordered an x-ray of the client's right leg, which revealed that the client sustained a right distal fibular fracture.

Due to the nature of the incident an on site investigation was initiated on October 29, 2008 to evaluate the GHMRPs system's for ensuring health and safety to its residents.

The findings of the investigation was based on observation at the group home and the day program; interviews with group home staff, day program staff, the Qualified Mental Retardation Professional (QMRP), the Registered Nurse and the HM, and the review of medical/clinical/administrative records.

1 291 3514.2 RESIDENT RECORDS

Each record shall be kept current, dated, and signed by each individual who makes an entry.

This Statute is not met as evidenced by:
The GHMRP failed to ensure person making entries in the medical record dated the entry for Resident #1.

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

STATE FORM

TITLE

(X6) DATE

EOFJ11

If continuation sheet 1 of 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G218	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/14/2008
NAME OF PROVIDER OR SUPPLIER WHOLISTIC SERVICES, X			STREET ADDRESS, CITY, STATE, ZIP CODE 1418 VAN BUREN STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
I 291	Continued From page 1 The finding includes: On October 23, 2008 the direct staff noticed that Resident #1's right leg was swollen from her knee to her ankle. The direct care staff reported the findings to the house manager. The house manager informed the Registered Nurse (RN) on the same day. The RN instructed the House manager, who was a Trained Medication Employee (TME) to administer pain medication to the resident. The Primary Care Physician (PCP) evaluated the resident on October 24, 2008. Interview with the Registered Nurse on October 28, 2008, at 11:30 AM revealed that the physician evaluated the resident on October 24, 2008. Review of the resident's record on the same day revealed a consultation form which which documented the resident's diagnosis and treatment plan. Although the physician signed the form, the physician failed to date the form.	I 291	<div style="border: 1px solid black; padding: 5px; width: fit-content;">I 291 Cross reference W114. + W153 12/01/08</div>		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that injuries of unknown	I 379			

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

09G218

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
COMPLETED

C

11/14/2008

NAME OF PROVIDER OR SUPPLIER

WHOLISTIC SERVICES, X

STREET ADDRESS, CITY, STATE, ZIP CODE

1419 VAN BUREN STREET, NW
WASHINGTON, DC 20012(X4) ID
PREFIX
TAGSUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)ID
PREFIX
TAGPROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)(X5)
COMPLETE
DATE

I 379

Continued From page 2

origin are reported to the facility's administrator and government agencies as required by DC Regulation (22 DCMR Chapter 35 Section 3919.10).

The findings include:

Review of an unusual incident report dated October 23, 2008, on October 29, 2008 revealed that Client #1 was discovered to have sustained swelling to the right leg from the knee to the ankle. The origin of the swelling was unknown. The incident report reflected that the client's leg was x-rayed on October 24, 2008 and revealed the client had a right distal fibular fracture. Further review of the Verbal Notification/Written Notification section of the incident report failed to show evidence that this incident had been reported immediately to the administrator or governmental agencies as required. Additionally the incident report reflects an October 27, 2008 date of notification to the State Agency (four days after the swelling was discovered).

I 379

I 379

Cross reference W153.

12/01/08